Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TX HEALTH DBA INJURY 1 OF DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name
HARTFORD FIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-13-0401-01

MFDR Date Received
OCTOBER 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of EOBs (1st & 2nd denials), claims, and documentation. The patient was referred for an Initial Behavioral Medicine Consultation. The service was provided and the claim was denied per EOB services rendered required preauth. CPT Code 90801 does not require preauthorization per rule 134.600. In summary, it is our position that Hartford Insurance has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to Ms. Gaytan."

Amount in Dispute: $1,148.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please be advised that The Hartford upholds the decision to deny services as the injured workers [sic] was placed at maximum medical improvement on 4/13/12 by a state designated doctor with a 0% impairment…."

Response Submitted by: The Hartford, PO Box 14187, Lexington, KY 40512

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 28, 2012	CPT Code 90801	$1,148.15	$1,148.15

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Service rendered requires pre-authorization.

- W4 – No addl reimbursement allowed after review of appeal/reconsideration. Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time. Service rendered requires pre-auth.

Issues

1. Does the service in dispute require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds that the requestor billed 5 units of CPT Code 90801, defined as "psychiatric diagnostic interview examination", which, in accordance with 28 Texas Administrative Code §134.600(p)(7), which states, "Non-emergency health care requiring preauthorization includes: all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program." The lay description for this code is described as "a psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering a medical interpretation of laboratory or other medical diagnostic studies." The respondent has not supported their denial nor have they reported this date of service as a "repeat interview"; therefore, this service does not require preauthorization.
2. Review of the submitted documentation finds that the requestor is due reimbursement in accordance with 28 Texas Administrative Code 134.203(b)(1) and (c) which states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1)Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. (c)To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications." The reimbursement is as follows:
    - CPT Code 90801 – (54.86 ÷ 34.0376) x $153.63 = $247.61 x 5 = $1,238.06. The requestor is seeking $1,148.15.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,148.15.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,148.15 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 25, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received

by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.